Department of Health
Child and Adolescent Mental Health Division

Performance Report

Performance Period January 2006-March 2006

Introduction

This report presents findings about the performance of operations and services of the Child and Adolescent Mental Health Division (CAMHD) during the third quarter of fiscal year 2006 (January 2006-March 2006). The information used for this report is based on the most current data available, and where possible are aggregated at both statewide and district or complex levels. Tracking and analyses of data provides information that allows stakeholders to determine how well CAMHD is delivering care and impacting child outcomes.

Data in this report are presented for four major areas:

- Population: Population information describes the demographic characteristics of the children and youth served by CAMHD.
- Service: Service information is compiled regarding the type and amount of direct care services provided.
- Cost: Cost information is gathered about the financial aspects of services.
- Performance Measures: Performance Measures, including Outcome data, are used to understand and track the quality of services over time and the performance of operations of the statewide infrastructure designed to provide needed supports for children, youth, and families. Outcomes are further examined to determine the extent to which services that are provided lead to improvements in the functioning and satisfaction of children, youth and families.

How Measures Are Selected and Used

CAMHD has successfully integrated the use of performance measures throughout its program for the purposes of measuring quality and performance and to align organizational goals with achieving results in core areas of service provision and supporting infrastructure. Measures are used to coordinate the work of the organization in order to achieve timely, cost-effective services that ultimately improve the lives of children, youth and families served.

The CAMHD Performance Management system allows CAMHD, at all levels, to look at its performance and use this information to make decisions about adjustments to its program. Performance data in CAMHD are tracked systematically across all aspects of service delivery and care. Services are monitored through tracking of trends and patterns found in utilization, program performance and satisfaction data, and examinations of practice and quality of services. This information helps determine how well the system is doing for youth, and how well youth are progressing. It is sensitive enough to ascertain if the system is performing better or worse for certain populations, and comprehensive enough to detect what aspects of care, and in what settings, problems may be occurring.

Further studies and special reports on the CAMHD population and services, including past editions of this report can be accessed at the CAMHD website at http://www.hawaii.gov/health/mental-health/camhd/resources/index.html.

Quality Improvement Highlights during the Reporting Quarter

Highlights of key activities conducted during the quarter include:

⇨ Intensive review was conducted of the proposals received pursuant to the CAMHD Request for Proposals for Home and Community-Based Services to:

- Provide eligible youth with timely access to community and evidence based services that are provided by qualified staff within a system of care that embodies Hawaii CASSP,
- Promote the use of current knowledge of evidence-based services in the implementation of individualized plans and services,
- Demonstrate an accountable and efficient children's mental health system,
- Implement an effective and efficient publicly managed behavioral health plan for Medicaid eligible youth with the most serious emotional challenges, and
- Demonstrate an effective, integrated cross-agency system of services for educationally disabled students who need mental health services in order to benefit from their education.

⇨ The CAMHD Statewide Management Team convened to begin planning for the development of CAMHD's Strategic Plan, and development of the new plan that will cover the next four years (2007-2010).

⇨ CAMHD staff and stakeholders presented at a number of symposia and workshops at the 19th Annual Conference of the Research and Training Center for Children's Mental Health (A System of Care for Children's Mental Health: Expanding the Research Base). The following are highlights of the presentations:

- Promoting Family Choice in Hawaii (Mary Brogan): The presentation focused on how the CAMHD service system promotes family choice by design based on the core practice of team-based planning and decision-making. This occurs through the Care Coordinator's primary role of engaging families in planning, and assisting them in making informed choices regarding care and being active in the service delivery process. The presentation described how the state's Care Coordinator model returns the value and power of the therapeutic relationship to clinical work and how both Care Coordinators and providers are supported by a practice infrastructure of data-based decision supports, training and supervision, and systematic updates on evidence-based services. Within this framework, Care Coordinators meet with each family upon entry into the service system to provide good information on rights and responsibilities, the service array, and service access to support good choices. Explicit practice expectations were described, including meeting families where they are at, conducting comprehensive ecological assessments that inform strength-based plans, and methods for helping families to navigate what can be an overwhelming and complex system.

- CAMHD staff and University of Hawaii partners presented a workshop entitled Multi-Level Systems Evaluation: Selected Projects from Hawaii, which included:

  Intensive Home and Community Services: Status of Twelve-Month Follow-Up (Deborah Roberts): Intensive In-Home (IIH) services are frequently provided in the CAMHD service array as a level of care that aims to meet the needs of youth and families in the community and avoid the disruption of out-of-home placement. The study followed youth receiving IIH services through CAMHD's Family Guidance Centers from 2001 through 2003, with a 12-month follow-up after intake. The authors evaluated the type of services accessed twelve months following system intake and characteristics of youth receiving more restrictive versus less restrictive services. Possible implications for program and system design were discussed.

  Cost-Quality Efficiencies: An Illustration of Data Envelopment Analysis (DEA) for Mental Health Delivery (T. Orvin Fillman): The presentation provided an overview and applied the DEA linear programming methodology to examine the relative efficiencies of Family Guidance Centers. Five resource input variables were compared to four quality output variables for services to youth. The results identified one center as relatively inefficient in terms of cost and quality, and concluded that the DEA methodology can be an important tool for concurrently focusing quality and financial improvement efforts within an evidence-based mental health delivery system.

  Validity of Treatment Target Progress Ratings as Indicators of Youth Improvement **(**Brad Nakamura and Charles Mueller): Presented was an investigation that utilized the target complaints scoring methodology for examining the relationship between progress ratings on idiographic treatment targets and changes in a standardized measure of functional impairment. Analyses were conducted with a sample of youth with data available at intake into the CAMHD system and after six months of treatment. Results indicated degree of improvement on idiographic treatment targets correlated with change (improvements) in global functioning directly, and when controlling for intake scores on both measures. Overall, results supported the use and continued development of target progress ratings.

Overall Summary of Findings

The overall results from the data and analysis presented below suggest that in general, CAMHD's functioning is comparable to that of previous quarters except in the area of vacancies. Human resources, particularly hiring and retaining qualified mental health care coordinators, remains a challenge that requires ongoing attention to stability in this core infrastructure component. The total number of youth served rebounded slightly, and the total size of the CAMHD population is larger than it was a year ago. Service utilization trends for Hospital continued to decrease, however use of Community Residential services increased slightly. Utilization of Therapeutic Foster Homes also continued to decrease over previous quarters, but increased over the same period last year.

Data Sources

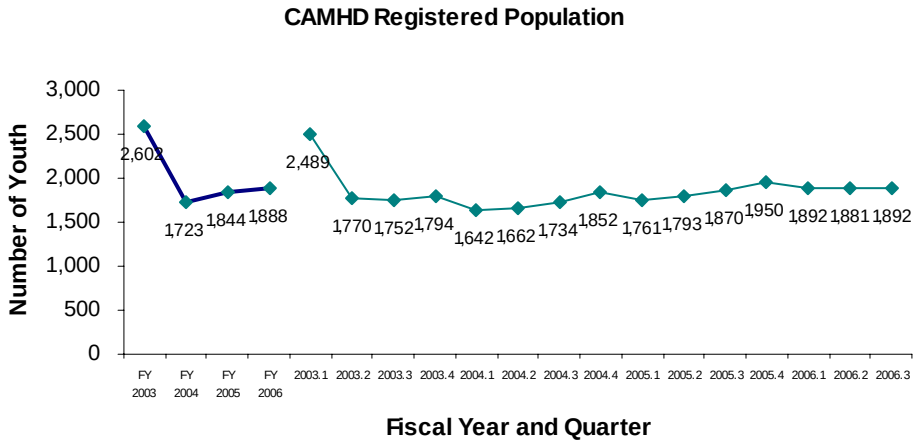
Data regarding the population served, access and use of services, cost, treatment processes and outcomes is generated at the Family Guidance Centers or through billing information, and collected through the Child and Adolescent Mental Health Management Information System (CAMHMIS). CAMHMIS produces data reports that are used by staff and management for tracking, decision-making, supervision and evaluation. CAMHMIS' multiple features include the ability to generate "live" client data, FGC-specific reports and other special reports that aid in performance analysis and decision-making. Additional data elements used to track Performance Measures are produced by various databases maintained at the State Level.

Population Characteristics

Population data presented here are for youth registered through the CAMHD Family Guidance Centers during the third quarter of fiscal year 2006 (January 2006-March 2006). In the quarter, CAMHD Family Guidance Centers provided care coordination for 1,892 youth across the State, an increase of 11 from the previous reporting quarter (October 2005-December 2005 based on data as of December 30, 2005), or a 1% increase in the total population over last quarter. Increases in the registered population were experienced in more than half of the Family Guidance Centers.

On a year-to-year basis, CAMHD is continuing to show overall growth in its registered population. In comparison to the same period of last year (January 2005-March 2005), CAMHD has experienced a 1% overall increase in its registered population. Although this quarter's numbers registered saw a slight rebound in the downward trend experienced in the last two quarters, CAMHD continues to serve fewer youth than expected based on estimates of the prevalence of severe emotional and behavioral problems in the general population. Expanding outreach to unserved populations and increasing overall population size has been identified as a need.

The chart below reflects changes in the CAMHD population over time.



Note: The drop in population at the start of fiscal year 2003 (July 2002) corresponds to the shift in management of services to youth with pervasive developmental disorders from CAMHD to the Department of Education.

The numbers of youth registered during the third quarter at each of the Family Guidance Centers are displayed in Table 1 below.

Table 1. Population of Youth Registered by Family Guidance Center

	COFGC	LOFGC	MFGC	WFGC	HOFGC	HFGC	KFGC	FCLB
Third Quarter FY 2006	151	244	165	133	163	454	536	44
Second Quarter FY 2006	156	251	162	141	170	429	528	43
Third Quarter FY 2005	162	233	158	149	164	488	521	35

Please note that the numbers for Kauai (KFGC) are for the Mokihana Project in total, which serves youth with both low and high intensity mental health needs. Also displayed are the numbers for the preceding quarter (Quarter 2, FY 2006), and the numbers for the same period one year ago (Quarter 3, FY 2005). The data show that there have been some minor but not significant fluctuation in population among the Family Guidance Centers, but overall the population has remained fairly stable over the last year.

In the current quarter (Quarter 3, FY 2006), the largest population, consistent with historical data, continued to be served on the Big Island through the Hawaii Family Guidance Center (HFGC). HFGC served 24.0% of the total CAMHD population during the quarter. The Leeward Family Guidance Center (LFGC) served the largest population on Oahu, which is 12.9% of the CAMHD registered youth. The Family Court Liaison Branch (FCLB), which provides services primarily for incarcerated and detained youth, continued to serve the smallest registered population (2.3%).

The total number of registered youth are described by four subgroups: (*i*) youth who received both intensive case management services and direct services authorized through the CAMHD provider network, (*ii*) youth who were in the process of having services arranged (new admissions), (*iii*) youth who received less intensive services through Mokihana on Kauai, and (*iv*) youth who were discharged at some time during the quarter. There is also a percentage of youth who receive intensive case management services only. Of the total number of registered youth, 962 had services that were authorized within the quarter.

Of the total registered population statewide (1,892), 138 youth (7.3%) were newly registered (had not previously received services) in the third quarter of fiscal year 2006. This represents a decrease of 9 new admissions from the previous quarter (October 2005-December 2005). One hundred seven (107) youth (5.7%) who had previously received services from CAMHD were reregistered, an increase from last quarter's readmissions of 88 youth. CAMHD discharged a total of 195 youth during the quarter, or 10.3% of the registered population. This is a decrease of 4 youth from last quarter's discharge of 199 youth, which was 10.6% of the registered population. Because youth may receive multiple admissions or discharges during the quarter for administrative reasons, these numbers estimate, but do not exactly reflect changes in the overall registered population size. Youth are generally discharged for several reasons, which can include attaining desirable treatment outcomes, graduation from school or "aging-out" of services, treatment refusal or program elopement, or moving out of state.

This pattern of admissions and discharges suggests that the reduction in the total registered population is resulting from a decrease in the number of new admissions, not an increase in the number of discharges. In other words, the services for youth registered with the system apparently proceeded as is typical, but "pathways" into the system provided fewer youth.

The average age and age range has remained relatively stable among the CAMHD population over the past few years. The average age of registered youth in the reporting quarter was 14.3 years with a range from 3 to 20 years. Approximately two-thirds (66%) of youth served during the third quarter were male (see Table 2). This continued the multiyear tendency toward a decreasing percentage of males and increasing percentage of females in the CAMHD population.

Table 2. Gender of CAMHD Youth

Gender	N	% of Available
Females	641	34%
Males	1,251	66%

CAMHD is continuing its effort to convert its collection of race and national origin data to be consistent with national standards. The national origin of youth is displayed in Table 3. The races of youth registered in the reporting quarter are displayed in Table 4. The valid completion rates for the new procedures remains relatively low with 60.0% of youth missing national origin information and 41.5% of youth missing race information, which makes the generality of the available data dubious. However, the observed results continued to be relatively consistent with prior quarters. Multiracial youth represented the largest racial group (62.6%), followed by White youth (17.3%), and then Native Hawaiian or Pacific Islanders (9.6%). National Origin data were not available (no data entered) for 60.0% of youth registered. Race data were somewhat less available this quarter than last quarter when 42.3% had race data recorded.

Table 3. National Origin of Youth (Unduplicated)

National Origin	N	% of Available
Not Hispanic	530	70.1%
Hispanic or Latino/a	226	29.9%
Not Available (% Total)	1,136	60.0%

Table 4. Race of Youth (Unduplicated)

Race	N	% of Available
American Indian or Alaska Native	1	0.1%
Asian	89	8.0%
Black or African-American	17	1.5%
Native Hawaiian or Pacific Islander	106	9.6%
White	191	17.3%
Other Race	10	0.9%
Multiracial	693	62.6%
Based on Observation	154	13.9%
Not Available (% Total)	785	41.5%

Subpopulations of youth who receive services through CAMHD are also involved with other public child-serving agencies. These agencies include the Department of Human Services (DHS), Family Court, Hawaii Youth Correctional Facility (HYCF) or Detention Home, and the Med-QUEST Division of DHS (see Table 5). In the quarter, 8.7% were involved with DHS, which continues a multiyear pattern of a progressively smaller proportion of youth involved with DHS (e.g., 9.7% during the same period of FY 2005). At some point during the quarter, 22.9% had a Family Court hearing during the quarter, and 5.3% were incarcerated at HYCF or detained at the Detention Home. Both of these proportions decreased slightly from the previous quarter (23.8% and 6.3%, respectively) and remain below the same period from last year (24.6% and 7.0%, respectively).

Table 5. Agency Involvement

Agency Involvement	N	%
DHS	165	8.7%
Court	434	22.9%
Incarcerated/Detained	101	5.3%
SEBD	746	39.4%
Quest	698	36.9%

Services to youth who are QUEST-eligible and have a Serious Emotional and Behavioral Disturbance (SEBD) occur by virtue of a Memorandum of Agreement (MOA) with the Med-QUEST Division. Youth who were eligible for services through the SEBD process numbered 746 and were 39.4% of the registered population. This was an increase of 22 youth, or a 3% increase in the SEBD category over the previous quarter (October 2005-December 2005).

QUEST-eligible youth who received services in the quarter were 36.9% of the population. This proportion of QUEST enrolled youth decreased from the previous quarter's highest proportion (38.8%), as well as number (729), of youth since CAMHD initiated reporting on this indicator. Although the data showed a decline in proportion of the population in the reporting quarter, the pattern of expanding services to QUEST youth continued. QUEST-eligible youth may also be eligible for services through CAMHD because of their educational or juvenile justice status.

Table 6. Diagnostic Distribution of Registered Youth

Any Diagnosis of	N	%
Disruptive Behavior	769	47.2%
Attentional	667	40.9%
Mood	544	33.4%
Miscellaneous	430	26.4%
Anxiety	334	20.5%
Substance-Related	263	16.1%
Adjustment	167	10.2%
Mental Retardation	40	2.5%
Pervasive Developmental	32	2.0%
Multiple Diagnoses	1,171	71.8%
Ave. Number of Diagnoses	1.8	

Note: Percentages may sum to more than 100% because youth may receive diagnoses in multiple categories.

Youth registered with CAMHD receive annual diagnostic evaluations using the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994). Children and youth may receive multiple diagnoses on the first two axes of the DSM system. To summarize this information, diagnoses are classified into primary categories and the number of youth receiving any diagnosis in each category is reported (see Table 6). The reported percentages may exceed 100% because youth may receive diagnoses in multiple categories.

The top three diagnoses of youth with registered services in the quarter were Disruptive Behavior disorders (47.2%), Attentional disorders (40.9%), and Mood disorders (33.4%). This quarter saw a decrease in the number of youth identified with Disruptive Behavior disorders, although there continues to be more youth with Disruptive disorders than those with Attentional disorders. Miscellaneous diagnoses accounted for 26.4% of youth in the CAMHD population. This category includes individual diagnoses that occur less frequently in the population including cognitive, psychotic, somatic, dissociative, personality, sexual, tic, impulse control, learning and eating disorders.

The majority of youth in the CAMHD registered population have co-occurring, or more than one diagnosis. In the reporting quarter, 71.8% of registered youth had more than one diagnosis, with an average of 1.8 diagnoses per youth. This is a slight decrease from the previous quarter (October 2005-December 2005) when 72.2% had co-occurring disorders. For those with services authorized, the percentage of youth with multiple diagnoses was even higher (77.0%) with an average of 2.2 diagnoses per youth, which means that over three quarters of youth that received services within the CAMHD array in the quarter had co-occurring diagnoses. This continues a long-term pattern of increasing diagnostic comorbidity among youth receiving CAMHD services. The co-occurring diagnoses category includes any DSM-identified disorder whether behavioral, developmental, emotional or substance-related.

In the quarter, youth with substance-related diagnoses represented 16.1% of the registered population, a decrease of .1% from the previous quarter. This statistic may not represent all youth with a substance-related impairment, or the number of youth with substance use identified as a target of intervention. Because diagnostic criteria for substance-related disorders require youth to exhibit a variety of symptoms and impairment, not all youth who use substances or who might benefit from interventions targeting substance use would be diagnosed with a substance-related disorder. Therefore, this statistic, which is drawn from the diagnostic category, is expected to underestimate the total number of youth experiencing a substance-related impairment.

Services

Service utilization information is used throughout CAMHD to assure efficient use and timely access to services. At the case level, service data are constantly reviewed to provide services based on child and family needs, and provision within the least restrictive environment. Tracking of utilization of the services at the aggregate level allows for accurate accounting, and data-driven planning and decision-making.

CAMHD tracks the utilization of services through CAMHMIS for services that are electronically procured. For services that are not electronically procured, information from the Clinical Services database is used to augment the CAMHMIS database to yield the final numbers reported here. CAMHD produces a separate detailed quarterly service utilization report with information regarding statewide utilization of services for all levels of care. As discussed previously, because utilization data are dependent on an accounting of claims adjudicated, it is not possible to present actual utilization for the current reporting quarter (January 2006-March 2006). Therefore, service authorization data are presented here, which closely approximates the actual utilization for the quarter for most levels of care.

Home and community based services continue to account for the majority of services provided to youth. Specifically, 50.0% of youth with services authorized received Intensive In-Home (IIH) services and 14.1% received Multisystemic Therapy (MST). Compared to the previous quarter, the percentage of youth (49.7%) receiving Intensive In-Home services showed a slight decrease, whereas the percentage of youth (14.9%) receiving Multisystemic Therapy services showed a slight increase.

Table 7. Service Authorization Summary (January 1, 2006-March 31, 2006).

Any Authorization of Services	Monthly Average	Total N	% of Registered	% of Served
Out-of-State	6	6	0.3%	0.6%
Hospital Residential	17	28	1.5%	2.9%
Community High Risk	8	8	0.4%	0.8%
Community Residential	101	144	7.6%	15.0%
Therapeutic Group Home	67	90	4.8%	9.4%
Therapeutic Family Home	127	148	7.8%	15.4%
Respite Home	0	0	0.0%	0.0%
Intensive Day Stabilization	0	0	0.0%	0.0%
Partial Hospitalization	0	0	0.0%	0.0%
Day Treatment	0	0	0.0%	0.0%
Multisystemic Therapy	104	136	7.2%	14.1%
Intensive In-Home	403	481	25.4%	50.0%
Flex	83	138	7.3%	14.3%
Respite	28	32	1.7%	3.3%
Less Intensive	45	104	5.5%	10.8%
Crisis Stabilization	8	19	1.0%	2.0%

Note: Youth may receive more than one service per month and not all youth will have a service procured each month, so the percentages may add to more or less than 100%. The monthly average to total census ratio is an indication of youth turnover with a high percentage indicating high stability.

The largest group of youth in an out-of-home setting received services in a Community-Based Residential program (15.0%). The percentage of youth receiving these services

increased slightly from the previous quarter (14.9%) and decreased slightly from the same period of last year (15.3%). Similarly, the use of Hospital-based Residential (HBR) services (2.9% during period) decreased slightly from the previous quarter (3.0%) and from the same period of last year (3.4%). This recent decline reverses a trend toward increasing utilization of HBR in recent years.

Although the quarter continued to experience the pattern of a decreasing utilization of the most restrictive out-of-home services, the utilization of Therapeutic Family Homes (15.4%) also decreased slightly this quarter over the previous quarter (15.6%), but increased over the same period of last year (14.4%). Utilization of Therapeutic Group Homes (9.4%) has fluctuated a bit from quarter to quarter (up from 9.2% in the previous quarter) and saw virtually the same utilization as a year ago (9.5%).

In the reporting period, Ancillary Services paid through Flex funding were provided for 14.3% of registered youth, which was a decrease from last quarter's utilization of these services for 16.4% of the registered population. Ancillary Services are designed to maintain youth in their homes (prevent out-of-home placements) through supports that are not found in the regular array of services, or to pay for specialized services. The largest use of Flex funding was to pay for travel cost for youth in out of home settings.

Respite Home services had no youth accessing this service in the current quarter, as well as the previous quarter. On an annualized basis, utilization has increased somewhat, but overall utilization of this service remains low. Respite Homes were designed to support caregivers' capacities and prevent potential out-of-home placements. The consistently low utilization of this service indicates either little need for this service or that potential barriers existing to accessing this service. One identified obstacle involves the funding and payment structure for these homes. Therefore, payment has been restructured in the new RFP to remove this obstacle for this level of care within the next generation of the service array. There was also no utilization of Intensive Day Stabilization Services. Intensive Day Stabilization has been replaced with Partial Hospitalization in the new RFP. Respite services are a different level of care than Respite Homes in that they do not need to be provided by a Therapeutic Foster Home provider and are more flexible in nature. Utilization of Respite services increased with 3.3% of youth accessing these services in the quarter.

Cost

CAMHD uses several sources of information about expenditures and the cost of services to understand cost across all services delivered. Services billed electronically and purchased through the provider network are recorded directly by CAMHMIS when the records are approved for payment (a.k.a. accepted records). Because cost data are available the quarter following the adjudication of all claims, the cost data discussed below represents expenditures for services provided during the second quarter of fiscal year 2006 (October 2005-December 2005). Unit cost information may not be available in CAMHMIS for certain types of services or payment arrangements (e.g., cost reimbursement contracts, emergency services). For these services, wherever possible, service authorizations are used to allocate the cost of services (e.g., Flex, Mokihana, Multisystemic Therapy, Out-of-State, Respite) to specific youth and Family Guidance Centers.

Detailed allocation of cost information for the reporting quarter by each level of care is presented in Table 8. Out-of-Home residential treatment services in Hawaii accounted for 81.7% of service expenditures, which is 1.4% below the previous quarter's percentage of cost. Youth in Out-of-State treatment settings accounted for 1.4% of total expenditures, which is 0.3% above the previous reporting quarter's (July 2005-September 2005) proportion of cost.

Table 8. Cost of Services (October 2005-December 2005)

Any Receipt of Services	Total Cost ($)	Cost per Youth ($)[a]	Cost per LOC ($)[b]	Cost per LOC per Youth ($)[b]	% of LOC Total ($)[b]
Out-of-State	157,446	26,241	141,302	23,550	1.4%
Hospital Residential	1,167,637	41,701	970,401	34,657	9.5%
Community High Risk	493,548	54,839	441,540	49,060	4.3%
Community Residential	3,707,548	26,295	3,252,774	23,069	31.7%
Therapeutic Group Home	2,056,147	22,595	1,756,217	19,299	17.1%
Therapeutic Family Home	2,554,423	16,587	1,957,971	12,714	19.1%
Respite Home	0	0	0	0	0.0%
Intensive Day Stabilization	0	0	0	0	0.0%
Partial Hospitalization	0	0	0	0	0.0%
Day Treatment	0	0	0	0	0.0%
Multisystemic Therapy	836,439	5,690	447,132	3,042	4.4%
Intensive In-Home	1,856,496	4,053	983,136	2,147	9.6%
Flex	3,476,008	21,325	212,979	1,307	2.1%
Respite	124,968	3,471	41,342	1,148	0.4%
Less Intensive	47,827	15,942	19,852	6,617	0.2%
Crisis Stabilization	70,974	8,872	25,316	3,164	0.2%

Note: a Cost per youth represents the total cost for all services during the period allocated to level of care based on duplicated youth counts. Thus, the average out-of-state cost per youth includes total expenditures for youth who received any out-of-state service. If youth received multiple services, the total expenditures for that youth are represented at multiple levels of care (duplicated US$). b Cost per LOC represents the unduplicated cost (US$) for services at the specified level of care. c Due to a billing error no accepted records were available for Hospital Residential services during FY2005 Q1. Therefore, data from provider census reports were used for this period.

The number of youth receiving Hospital Residential services continued to decrease. In conjunction with the decreased census, the current quarter witnessed a decrease in the average length of service in the Hospital setting. Accordingly, the total cost of services for youth who received Hospital Residential services during the quarter decreased from $1,310,785 to $1,167,637. The cost for Hospital Residential services also decreased ($970,401 compared to $987,040 in the prior quarter). However, the cost per youth increased from $40,962 to $41,701 for total costs and from $30,845 to $34,657 for Hospital Residential costs only.

Along with the decrease in authorization of Community-Based Residential (CBR) during the second quarter of fiscal year 2006, utilization of this service has been decreasing. Accordingly, the cost of CBR services decreased in the reporting quarter (i.e., second quarter of fiscal year 2006 compared to first quarter of fiscal year 2006) both in terms of total dollars and average cost per youth. Youth with high-risk sexualized behaviors who received treatment services in a Community High-Risk Program at some point during the quarter had the highest total cost per youth ($49,060 per youth), which decreased from the previous quarter. For other types of residential treatment, the lowest cost per youth was for those who received services in Therapeutic Foster Homes ($12,714 per youth), which has been consistent over time.

In-Home (Intensive In-Home and MST) and Less Intensive services accounted for 14% of the unduplicated cost of services. This is a slight increase from the last reporting quarter (July 2005-September 2005) percentage of total costs for those categories, and this has been a trend over the past five quarters. Youth receiving Intensive In-Home services at some point during the quarter cost an average of $4,053 per youth ($2,147 of which was for Intensive In-Home service expenditures only), which continues to be significantly less than the cost per youth in any residential program.

For those youth who received Ancillary Services, average cost per youth for the Flex funded services only was $1,307 per month and the average cost for all services to those youth who received one or more Ancillary services was $21,325 per youth. The average cost per youth for a child receiving a Flex-funded service at some point during the quarter also includes their service costs in other levels of care, and may include residential services. The high average total cost per youth for these services suggest that youth in out-of home placements account for a high percentage of youth receiving a Flex-funded service. A high proportion of Flex-funded services are travel-related including family visits when placement is off-island. As previously reported, CAMHD is in the process of adding travel costs to the MOA with the Med-QUEST Division for QUEST-eligible youth, allowing the State to recoup federal funds for a portion of this cost. This agreement will apply retrospectively.

Comprehensive information on expenditures beyond the services tracked by CAMHMIS is obtained through the Department of Accounting and General Service's Financial Accounting Management Information System (FAMIS). For this report, FAMIS provided information regarding total general fund expenditures and encumbrances for the central and branch offices that are reported in the Performance Measures section. However, it is important to note that FAMIS tracks payments and encumbrances when they are processed at the Departmental level. Due to the time lag between service provision and payment, the CAMHMIS and FAMIS systems do not track the same dollars within any given period. Therefore, estimates provided here are used for general guidance, and detailed financial analysis is conducted by CAMHD Administrative Services.

Recent developments to the chart of accounts in the financial accounting system allows for more specific coding of purchases into specific service categories. Therefore, as the system continues to develop and new reporting functions are programmed, comprehensive financial reports providing detailed service expenditures should be available from FAMIS. This should lead to reduced burden for manual reporting and increase the capacity of the fiscal section to perform timely and thorough financial analysis.

Services for Youth With Developmental Disabilities

CAMHD entered into a Memorandum of Agreement (MOA) with the Developmental Disabilities Division (DDD) of the Department of Health in July 2002 for the purposes of serving the needs of those youths with mental retardation and/or developmental disabilities and/or autism (target population) who had previously received respite and out-of-home services through CAMHD. The MOA transferred funding and personnel to DDD so that these children could receive appropriate individualized supports consistent with national best practices in developmental disabilities.

The table below summarizes the expenditure of dollars for respite services provided by DDD from July 1, 2002 through March 31, 2006:

Table 9. Expenditures to Date for Respite by Island

Island	# Youth Served	% of Total Youth	Total Cost Per Island	% of Total Dollars Expended	Average Cost Per Youth
Oahu	73	55%	$148,303.93	44%	$2,031.56
Hawaii	34	26%	$89,714.00	27%	$2,638.65
Kauai	11	8%	$61,644.50	18%	$5,604.05
Maui	14	11%	$37,358.00	11%	$2,668.43
Total Youth	132	Total Dollars Expended (July 2002 - March 31, 2006)			$337,020.43

Note: There are currently no reports of respite expenditures for the period January 2006 through March 2006.

Although the MOA ended on June 30, 2004, DDD continues to provide case management, individual support, respite, and out-of-home support services for the identified target population. DDD utilized the respite monies transferred from CAMHD as part of its state match for its HCBS-DD/MR Medicaid waiver program, thereby maximizing state funds and qualifying DDD services for federal reimbursement.

Respite Services

The target population received at least one support service from the DDD service system. For this current quarter, January 1, 2006 through March 31, 2006, the following table shows the utilization of various DDD funded services (short term) that families accessed to meet their needs:

Table 10. Other Service Options Utilized by Respite Recipients

DDD Funded Services	# of Users
Purchase of Services - Partnerships in Community Living	13
DOH - DDD Respite	29
Family Support Services Program	9

In addition, since July 2002, DDD has admitted 62 of the target population into the Home and Community Based Services – DD/MR (HCBS-DD/MR) Medicaid waiver program. Of the 62 individuals, 1 was admitted in the third quarter of FY06. There were no client discharges from waiver during this time period.

Based on the latest expenditure information available for the period October 1, 2005 through December 31, 2005, the following table shows the number of clients in the target

population and total dollars spent for two of the HCBS-DD/MR Medicaid waiver services, respite and personal assistance:

Table 11. Waiver Service Options Utilized by Respite Recipients

Waiver Services (August 1, 2005 – December 31, 2005)	# of Clients	Total $
Respite	9	$22,182.00
Personal Assistance	42	$355,867.00

Note: Amounts are rounded off to the nearest dollar.

Residential Services

DDD extended the Individual Community Residential Support (ICRS) contract until June 2006. Currently, ICRS provides for special treatment facility services for three youths. A third youth, part of the identified in the target population, was admitted to the facility in December 2005 in coordination with the DOE.

All but one individual of the thirteen youths that originally received ICRS services have been admitted to the HCBS-DD/MR waiver program. This one individual remains in a psychiatric facility, and, although discharge has been recommended, transition to community-based services has not occurred.

Performance Measures

CAMHD performance measures to demonstrate adequacy of services, results, infrastructure, and key practice initiatives are found in this section. If baseline performance falls below the established goals, CAMHD systematically examines the trends and any barriers, and develops strategies to achieve each goal. A stable pattern of results (i.e., a flat line) indicates that CAMHD is sustaining performance at baseline levels. A line that exceeds its benchmark indicates that CAMHD has surpassed its performance goals.

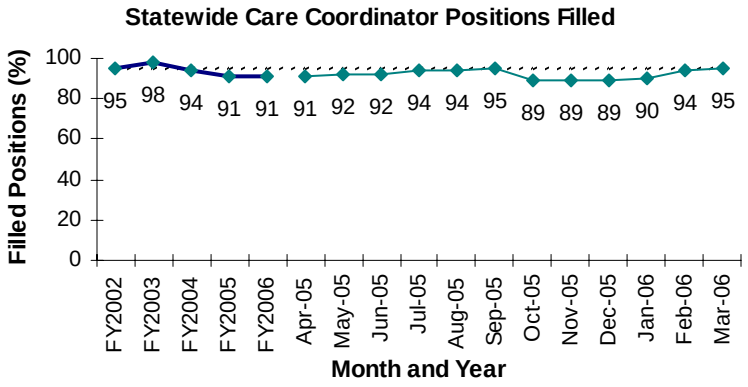
Performance measures linked to "measures of sustainability" are noted by an asterisk (*).

CAMHD will maintain sufficient personnel to serve the eligible population

Goal:

⇨ 95% of mental health care coordinator positions are filled.*

Over the reporting period, CAMHD had an average of 93% of care coordinator positions statewide filled, which was 2% below the performance goal, but above last quarter's performance of 89%. This quarter's result reflects the ninth consecutive quarter the performance goal was not met. The length of time it takes to fill care coordinator positions within the State personnel hiring process continues to impact performance on this goal. To address this, a number of FGCs have begun filling vacant positions with temporary (89-day) hires, which provides some support, but may not fully address the issue of assuring stability in CAMHD's case management function. Of the total number of care coordinator positions (76), six, or 9%, are filled with temporary hire personnel. In one unit (Pahoa), 50% of the care coordinator positions are filled with temporary hires.



The percentage of filled Care Coordinator positions over the quarter for each Family Guidance Center is displayed below.

COFGC	LOFGC	MFGC	WOFGC	HOFGC	HFGC	KAUAI
88%	90%	89%	88%	100%	95%	100%

As seen above Central, Leeward, Maui, and Windward, or over half of the FGCs, fell below the performance goal. Each of the centers that did not

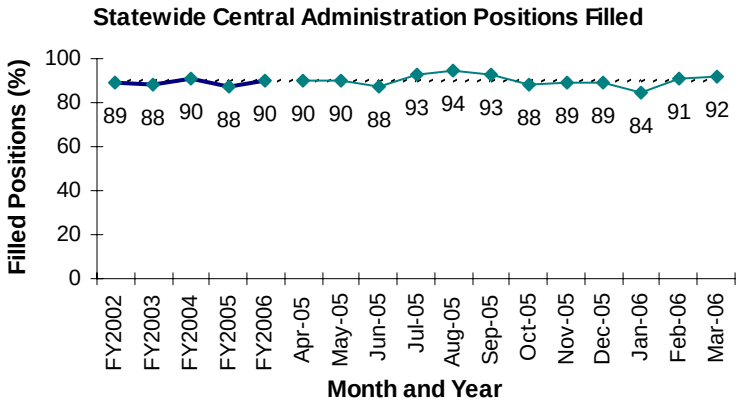
meet the goal experienced one to two vacancies during the quarter. The inability to fill positions impacts caseloads, and as explained in an analysis later in this report, overall FGC performance. As a strategy to improve human resource management, Branch Chiefs receive weekly briefings from the CAMHD personnel office to facilitate communication and understanding when hiring obstacles are encountered.

Goal:

⇨ 90% of central administration positions are filled.*

The performance target did not meet the desired performance with an average of 89% of central administration positions filled over the quarter. This coincides with last quarter's performance of 89% and represents the second consecutive quarter CAMHD has missed the performance goal. Similar to the Family Guidance Centers, the central administrative offices have filled a number of positions with temporary hire. Of the total number of position in the central administrative offices (77), seven, or 9% are filled with temporary hires. The use of temporary hires in a service system presents a number of challenges in terms of stability and quality. Recent developments regarding the inability to fill exempt position is further impacting CAMHD.

Vacant positions are distributed throughout central administration, with all offices experiencing some vacancies. Vacant positions are reviewed and recruited where possible through the civil service system to support the realignment of exempt and civil service positions.

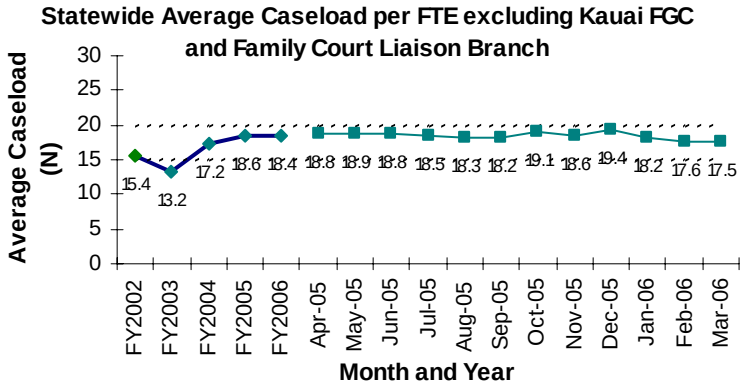


Goal:

⇨ Average mental health care coordinator caseloads are in the range of 15 - 20 youth per full time care coordinator.

The statewide average caseload for the third quarter was within the target range at 17.8 youth per full time care coordinator equivalent (FTE), which meets the performance goal for the measure. Each of the three months in the quarter met the performance expectation. CAMHD expects that care coordinator caseloads consistently fall in the range of 15 to 20 youth per full time care coordinator in order to provide quality intensive case management services. Average caseloads have consistently been in the

targeted range since the beginning of fiscal year 2004 and have been in the high end of the range statewide for nearly two years.



The average caseload performance target was not met for Leeward Oahu, where caseloads were above the expected range. Central and Hawaii are at or nearing the upper end of the expected caseload for care coordinators in the FGCs.

Average Caseloads by Family Guidance Center

	COFGC	LOFGC	MFGC	WOFGC	HOFGC	HFGC
3rd Quarter Average	19	22	16	16	17	18

The calculation of average excludes Kauai, which serves both high-end and low-end youth through the Mokihana project, and therefore have higher caseloads. Family Court Liaison Branch is also excluded because staff provide direct services to youth while at Detention Home or Hawaii Youth Correctional Facility, the majority of which are receiving care coordination from another Family Guidance Center.

CAMHD will maintain sufficient fiscal allocation to sustain service delivery and system oversight

Goal:

⇨ Sustain within quarterly budget allocation.

CAMHD met the goal for sustaining within its budget. The reporting quarter for this performance measure is October 2005-December 2005, which allowed for closing of the contracted agency billing cycle. Expenditures for Branch and Services totals were below budget ($416,000 and $351,000 respectively). The Central Office total was over budget by $118,000. Total variance from the budget for the reporting quarter was under projection by $382,000. Sufficient funds were encumbered for all expected service costs.

Variance from Budget (in $1,000's)

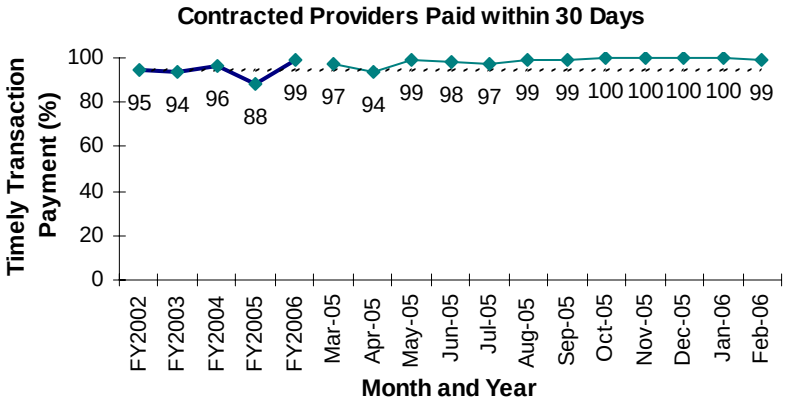
	FY 2002 Average	FY 2003 Average	FY 2004 Average	FY2005 Average	FY2006 Average	2005.1	2005.2	2005.3	2005.4	2006.1	2006.2
Branch Total	$164	-$150	$20	-$242	-$287	$20	-$337	-$338	-$312	-$159	-$416
Services Total	$798	-$4,175	-$1,849	-$102	-$228	-$2	-$203	-$155	-$49	-$105	-$351
Central Office Total	-$189	-$388	-$314	$68	$133	-$15	-$30	$86	$231	$148	$118
Grand Total	$773	-$4,713	-$2,142	-$276	-$382	$4	-$571	-$407	-$129	-$116	-$648

CAMHD will maintain timely payment to provider agencies

Goal:

⇨ 95% of contracted providers are paid within 30 days.

This quarter, 99.5% of contractors were paid within the 30-day window over the quarter. This is a slight decrease over last quarter's average of 100% of contracted providers paid within 30 days, but meets targeted performance for this measure. The performance goal has been met consistently since May 2005.



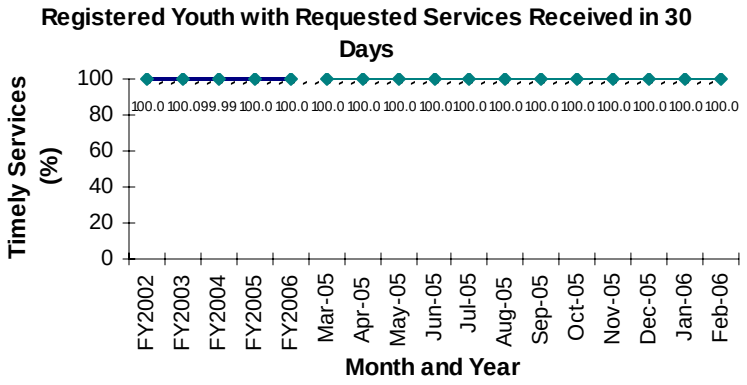
As is standard for this report, the quarter's data is available for the first two months of the quarter (January and February 2006) and includes December 2005.

CAMHD will provide timely access to a full array of community-based services

Goal:

⇨ 98% of youth receive services within thirty days of request.*

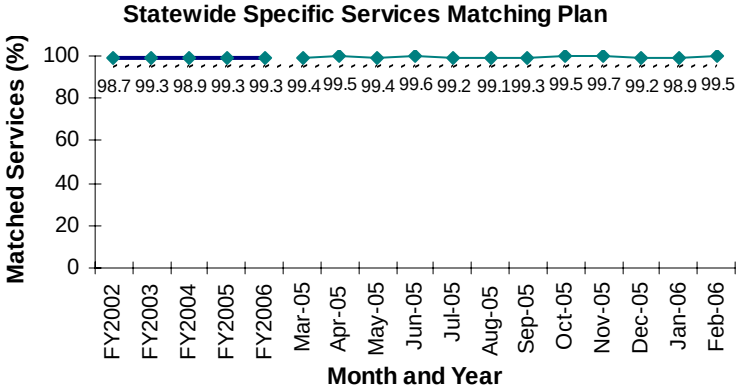
The goal was met for the quarter with 100% of youth provided timely access to services. Data are for the first and second month of the reporting quarter (January and February 2006) as third month data are not available at the time of publication. December 2005 data are included in the average for the quarter. This measure has consistently met the goal since it began to be tracked in fiscal year 2002.



Goal:

⇨ 95% of youth receive the specific services identified by the educational team plan.*

CAMHD continued to demonstrate strong performance on this measure. Over the quarter, 99.2% of youth received the specific services identified by their team plan. Data are for the first and second month of the reporting quarter (January and February 2006) as third month data are not available at the time of publication. December 2005 data are included in the average for the quarter. This measure includes SEBD youth who do not have an educational plan.



In the quarter, service mismatches occurred in twelve complexes versus ten in the previous quarter. Kailua, Waiakea, and Waipahu Complexes each had three youth receiving mismatched services. The remaining complexes experiencing mismatches of one each. Castle, Hilo and Kapolei had continuing mismatches from the previous quarter. Hilo has

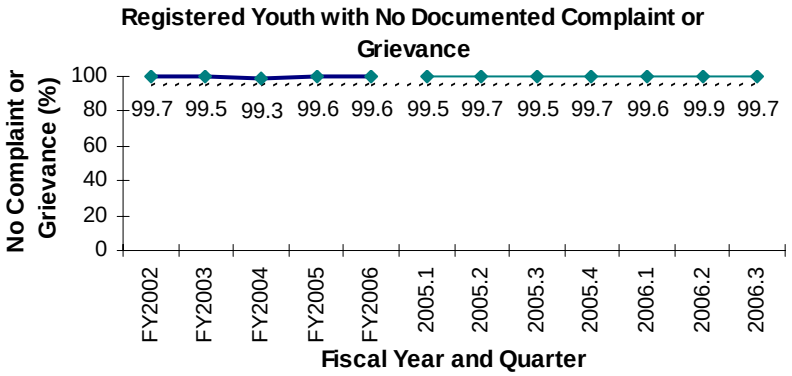
had at least one mismatch for the last ten quarters (since June-August 2003). The regional FGCs and the Utilization Management Committee regularly conduct analyses of the mismatches. Recommendations for service expansion have been collected and have been integrated where appropriate into the RFP for the updated service array.

CAMHD will timely and effectively respond to stakeholders' concerns

Goal:

⇨ 95% of youth served have no documented complaint received.*

99.7% of youth served in the quarter had no documented complaint received, which exceeds the performance goal. The target was met across all Family Guidance Centers. Performance on this goal has been sustained since it was established in June 2001.

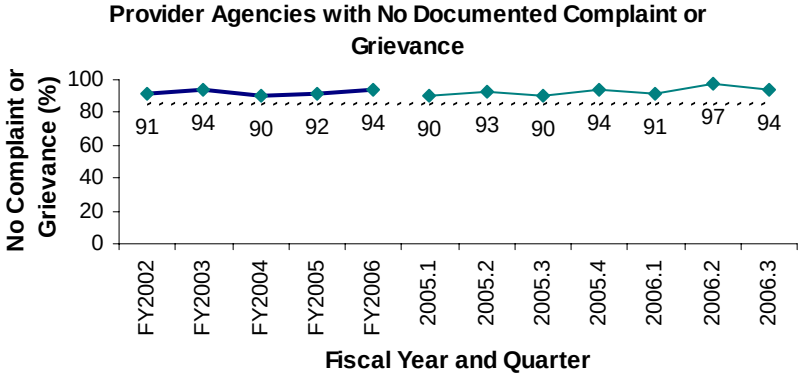


In the quarter, there were complaints received from 4 youth (or someone complaining on their behalf) representing 3 complexes statewide as compared to 4 youth with documented complaints representing 4 complexes last quarter. There was one complaint for each of the following complexes: Campbell, Kapolei, and Nanakuli, which are all serviced by the Leeward Family Guidance Center. Campbell and Kapolei also had complaints last quarter.

Goal:

⇨ 85% of provider agencies have no documented complaint received.

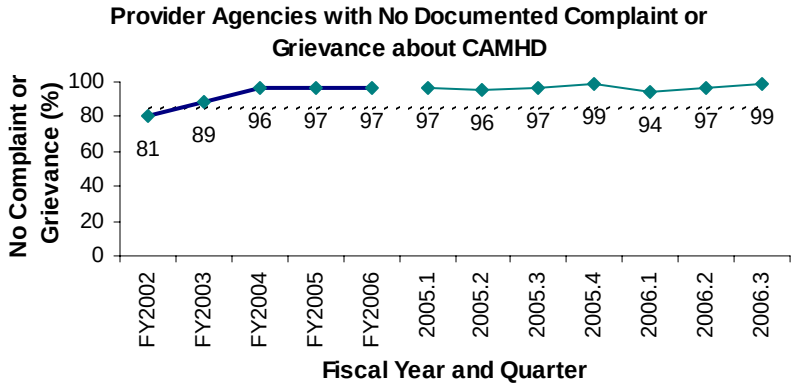
94% of provider agencies had no documented complaint registered about their services, which met the performance goal. The performance target for this measure has been consistently met since the second quarter of fiscal year 2004.



Goal:

⇨ 85% of provider agencies will have no documented complaint about CAMHD performance.*

In the quarter, 99% of agencies in the CAMHD provider network had no documented complaint or grievance about CAMHD. This measure has consistently met the performance goal since the beginning of FY 2003.



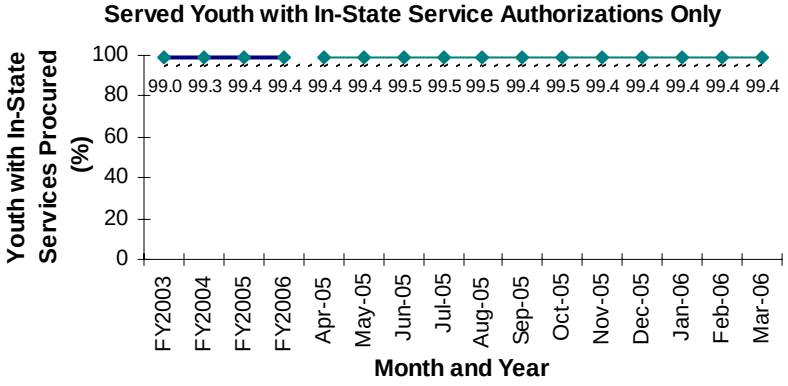
Youth will receive the necessary treatment services in a community-based environment within the least restrictive setting

Goal:

⇨ 95% of youth receive treatment within the State of Hawaii.*

In the quarter, an average of 99.4% of CAMHD registered youth served received treatment within the State, which exceeds the goal. Six youth received services in out-of state treatment settings in each month of the quarter.

These data represent only youth registered with CAMHD who were in out-of-state treatment settings in the reporting quarter, and does not represent youth who may have this service paid for by other State agencies.



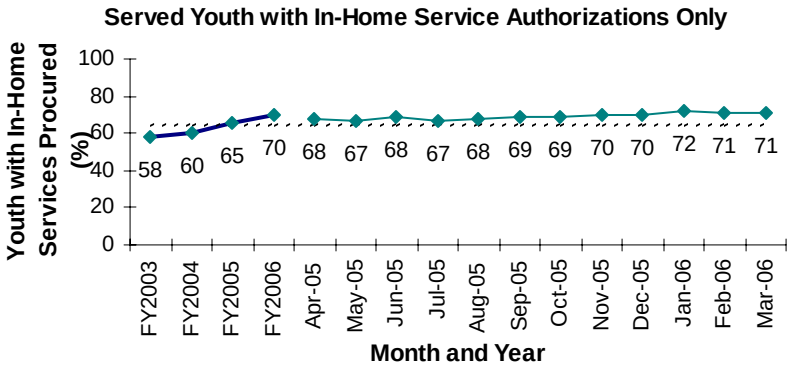
Goal:

⇨ 65% of youth are able to receive treatment while living in their home.

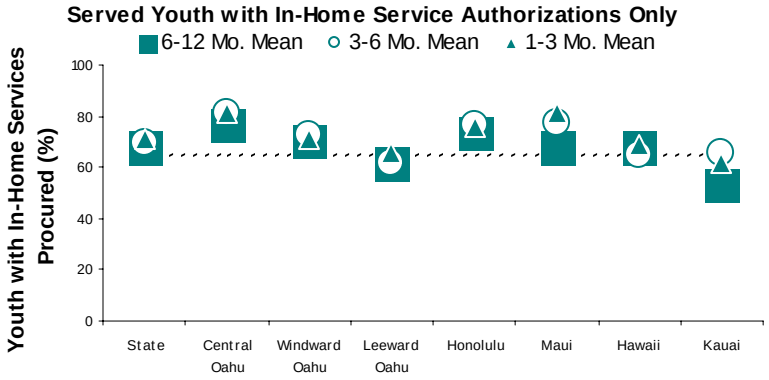
An average of 71% of youth were served in their home communities during the quarter, which is 6% above the performance goal. This quarter's performance was above last quarter's average of 63% of youth served in their homes. The in-home services performance measure is calculated at the percent of youth who did not receive an out-of-home service authorization during the quarter and either received an in-home service authorization or were enrolled in the CAMHD Support for Emotional and Behavioral Development (SEBD) program divided by the total number of youth with a service authorization or SEBD enrollment during the period.

These data have been adjusted since late 2004. In December of 2004, a new system was implemented to help improve the recording of youth enrolled in the SEBD by the Family Guidance Center personnel. As the new system has matured over the past year, the quality of information related to SEBD enrollment has progressively improved. Over the past two quarters, focused efforts were aimed at reconciling the multiple systems for recording and reporting SEBD enrollment. In accord with this initiative, the new SEBD information was used to recalculate the historical performance on this performance indicator since December 2004. This adjustment does not change the definition or interpretation of this indicator, but should yield a more accurate result.

The pattern of improved performance on this measure reflects both the expansion of the SEBD program and increased use of home and community services coinciding with decreased utilization of residential services over the past year.



There was variable performance across the Family Guidance Centers in meeting the goal as can be seen below. The goal was met for Central Oahu (81% served in-home), Windward Oahu (71.2% served in-home), Leeward Oahu (65.8% served in-home), Honolulu (75.5% served in-home), Maui (81% served in-home), and Hawaii (69.1% served in-home). With almost all of the FGCs exceeding the performance goal in the quarter and improving over last quarter's performance, it is suggested that the goal be re-evaluated within the context of this emerging trend.



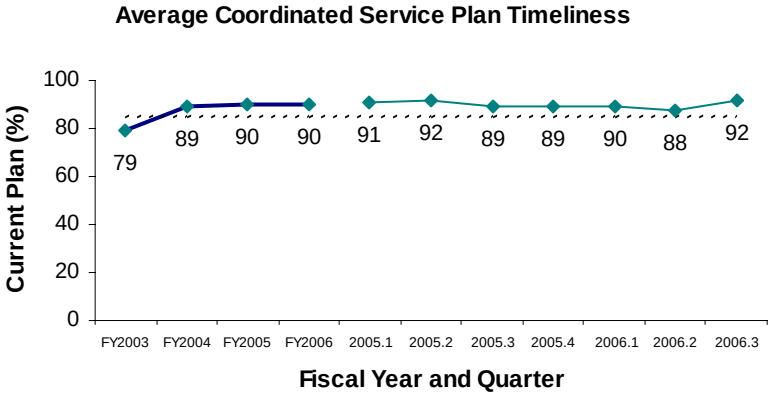
Serving youth in their homes and home communities when such services are likely to be effective continues to be a core value for CAMHD. Both the Leeward Oahu and Hawaii Family Guidance centers have historically had higher out-of-home service rates, however the proportion of youth showing positive outcomes from these centers are comparable to other centers in the state.

CAMHD will consistently implement an individualized, child and family centered planning process

Goal:

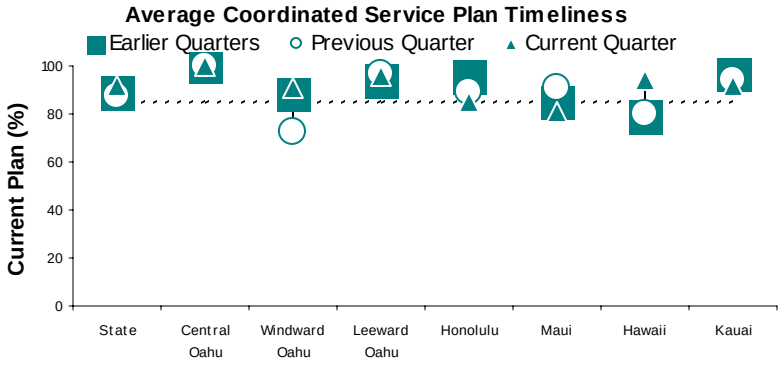
⇨ 85% of youth have a current Coordinated Service Plan (CSP).*

CAMHD's performance in this measure met the performance goal for the reporting quarter with 92% of youth across the state having a current CSP. The average for the year is 90%. The performance has remained stable statewide and the goal has been met for the past two and a half years.



Note: This data includes youth who were newly admitted to CAMHD who have not yet had a CSP developed, but does not include youth awaiting an assessment for determination of SEBD.

"Current" is defined as having been established or reviewed with the CSP team within the past six months. Quarterly reviews of timeliness are conducted to assess for current CSPs. Registered youth receive an initial Coordinated Service Plan within 30 days of determination of eligibility.



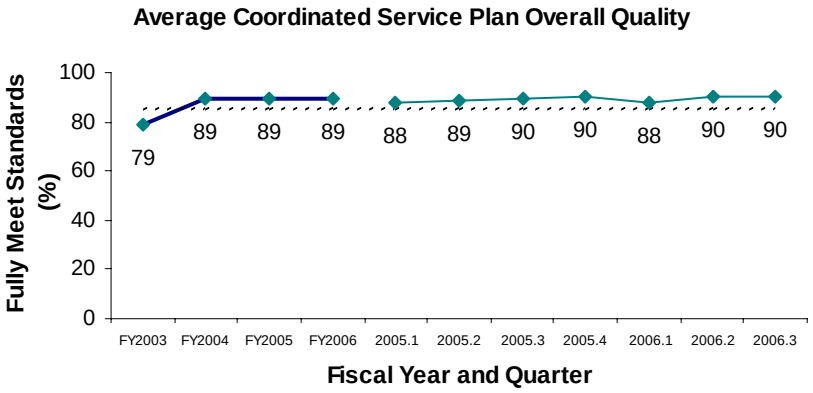
Trend data for each FGC are displayed above. The goal was met in six of seven FGCs. Hawaii FGC's improvement strategies of increasing supervision and filling a vacant Mental Health Supervisor position has had an impact in the performance of this indicator over time. Windward FGC, which had seen decreases in timeliness over the previous two quarters, showed an increase in timeliness in the third quarter.

A decline resulting in non-attainment of the performance goal was seen in the Maui FGC. Honolulu's results also declined.

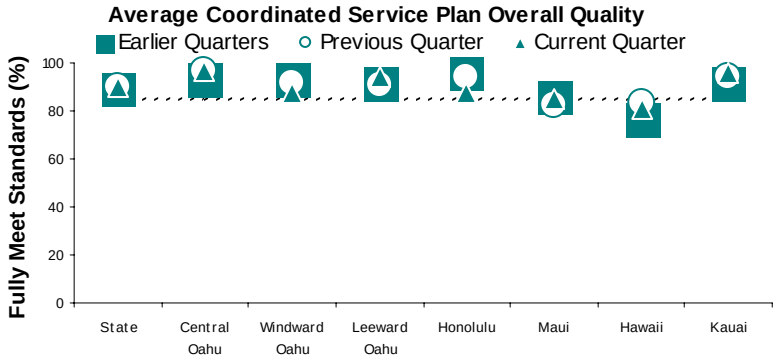
Goal:

⇨ 85% of Coordinated Service Plan review indicators meet quality standards.*

The goal for this measure was met statewide in the reporting quarter with 90% of CSPs sampled meeting overall standards for quality. The goal has been met for the past two and a half years at the statewide level.



CSPs are reviewed quarterly by the FGCs to determine if they meet the standards for effective plans. In order for a CSP to be deemed as acceptable overall, there must be evidence that the plan is meeting key quality indicators including stakeholder involvement, clear understanding of what the child needs, individualization of strategies, identification of informal supports, long-term view, plan accountability, use of evidence-based interventions, crisis plans and several other key measures.



As seen in the chart above, the goal was met or exceeded by all FGCs with the exception of Hawaii FGC, which experience a slight dip in performance, but is still performing better than in earlier quarters.

Mental Health Services will be provided by an array of quality provider agencies

Goal:

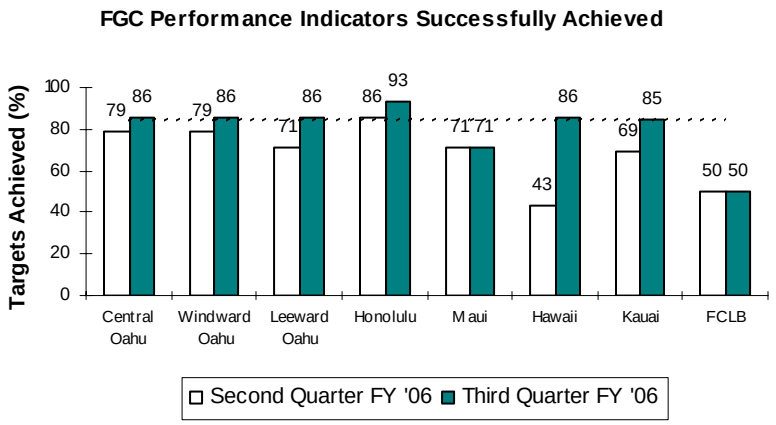
⇨ 85% of performance indicators are met for each Family Guidance Center.

Six of the eight Family Guidance Centers met the performance goal this quarter; Central Oahu, Windward Oahu, Leeward Oahu, Honolulu, Big Island, and Kauai, as compared to one last quarter. Family Guidance Center performance is evaluated based on the percentage of performance targets that are met or exceeded in the quarter. Performance targets are comprised of the relevant measures presented in this report, and include individual FGC performance on: personnel measures, expenditures within budget, grievances, access to services (service gaps/mismatches), least restrictive environment (served in-home), timeliness and quality of coordinated service plans, performance on internal reviews, improvements in child status, and family satisfaction. Improvements were seen in the quarter in many of these indicators.

Across all branches, 80.4% of all goals were met in the quarter, compared to 68.5% in the last quarter, and 80.1% over the same period last year.

Windward, Leeward, Big Island, and Kauai showed improvement over the previous quarter and over the same period of last year. Central and Honolulu FGCs showed improvement over the previous quarter, but compared to the same period last year, Central showed a decline whereas Honolulu remained stable. Maui FGC and the Family Court Liaison Branch (FCLB) did not meet performance goals.

Due to its unique configuration, the FCLB is only evaluated for the two indicators of expenditures within budget and percent of youth showing improvement on the CAFAS or ASEBA. Therefore these results tend to be highly variable and are not directly comparable to other branches.



The branches did well on indicators of:

- timely access to services,
- documented complaints from consumers,
- serving youth in the State, and
- completing the CAFAS or ASEBA.

One or two branches did not meet goals for:

- average caseloads
- maintaining within budget,
- serving youth while they are living at home,
- timeliness of Coordinated Service Plans,
- quality of Coordinated Service Plans, and
- youth showing improvements as measured by the CAFAS or ASEBA,

Roughly half the branches did not meet goals for:

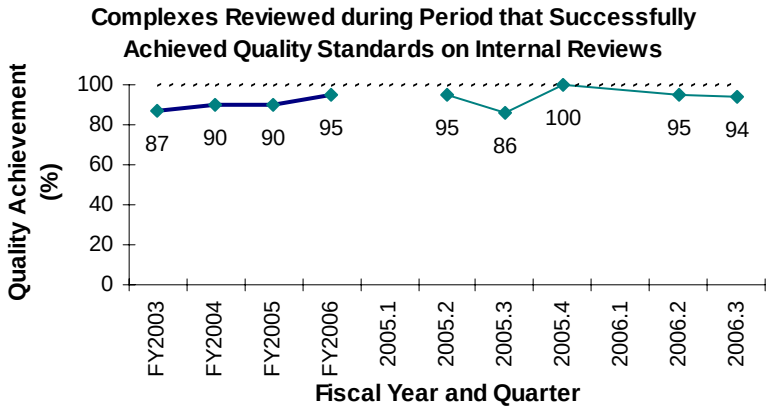
- filling care coordinator positions, and
- youth with acceptable child well-being in Internal Reviews.

Performance goals not met by a Family Guidance Center are addressed through specific improvement strategies developed by the FGC internal quality assurance committee, and reported up through the CAMHD Performance Improvement Steering Committee. Each FGC management team tracks the implementation of their improvement strategies.

Goal:

⇨ 100% of complexes will maintain acceptable scoring on internal reviews.*

Complex internal reviews for the school year continued in the third quarter. Of the seventeen complexes reviewed, 94% met the performance goal. One complex, Hana, did not meet the system performance goal. And two complexes, Hana and Kailua, did not meet the child status goal. Acceptable scoring continues to be defined as achieving acceptable system performance and child status for 85% of cases reviewed. The performance target is for 100% of complexes to meet the goal for acceptable system performance and child status.

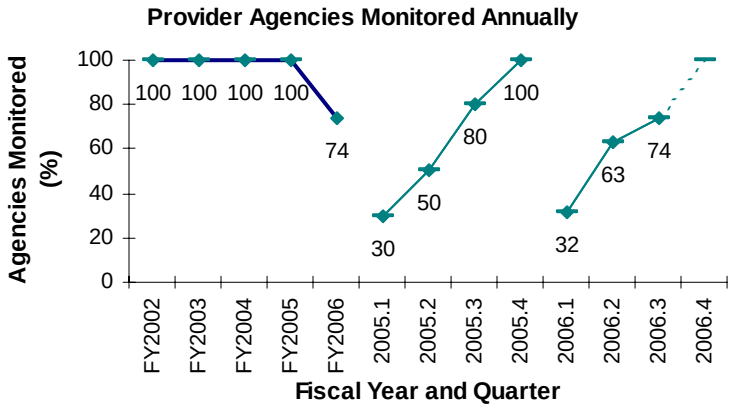


Mental Health Services will be provided by an array of quality provider agencies

Goal:

⇨ 100% of provider agencies are monitored annually.

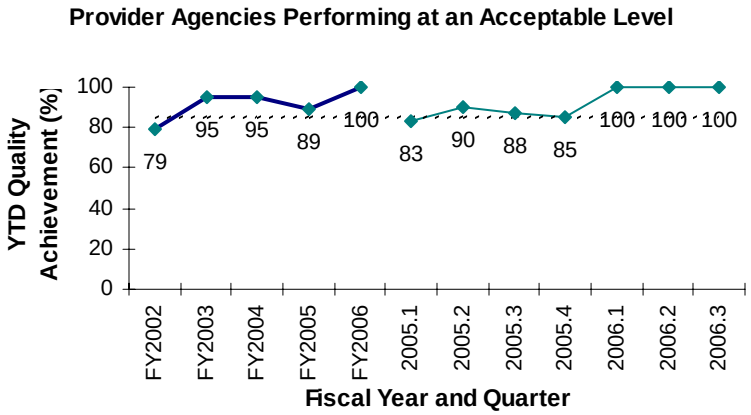
The CAMHD Performance Management Section conducts comprehensive monitoring of all agencies contracted to provide mental health services. In the quarter, 74% of all agencies contracted to provide direct mental health services were monitored as scheduled, which met the targeted goal. Two agencies, representing two contracts and three levels of care were monitored in the third quarter.



Goal:

⇨ 85% of provider agencies are rated as performing at an acceptable level.

At least annually, provider agencies are reviewed across multiple dimensions of quality and effective practices. In the reporting quarter, 100% of the provider agencies reviewed in the quarter were determined to be performing at an acceptable level, which met the performance goal for this measure. Because monitoring occurs over an annual season, the annual indicator is more reliable than the quarterly indicator.

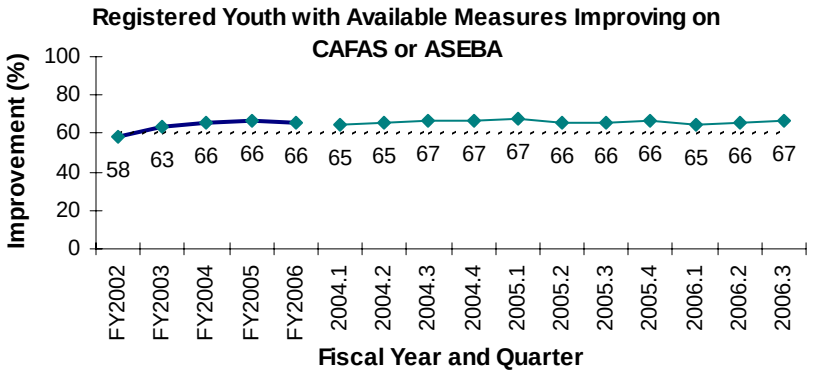


CAMHD will demonstrate improvements in child status

Goal:

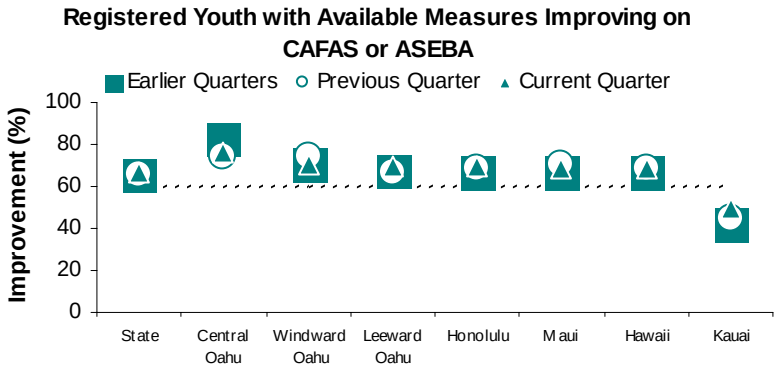
⇨ 60% of youth sampled show improvement in functioning since entering CAMHD as measured by the Child and Adolescent Functional Assessment Scale (CAFAS) or Achenbach System for Empirically Based Assessment (ASEBA).*

To monitor performance of CAMHD's goal of improving the functioning, competence and behavioral health of youth, care coordinators are required to submit the CAFAS and ASEBA for each youth. The performance goal is measured as the percentage of youth sampled who show improvements since entering CAMHD services and is set at 60%.



In the reporting quarter, for youth with data for these measures, 67% were showing improvements since entering the CAMHD system, which exceeds the performance goal. This indicator had demonstrated improvements from fiscal year 2002 to 2004, but has settled on a new plateau of approximately two-thirds of youth showing improvement at any given point in time, and the benchmark for this measure should likely be adjusted.

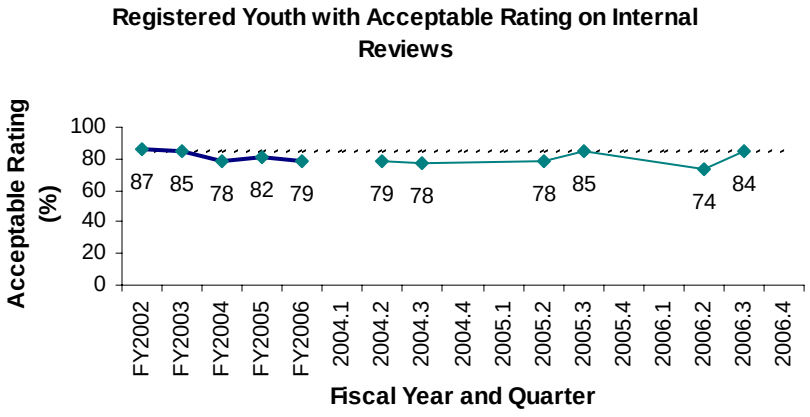
Most branches are performing near the state average with the exception of Kauai, which historically has performed below the average. Kauai's population differs from the other branches due to the Mokihana project, so the branch-to-branch results are not directly comparable. Windward Oahu, which had been performing well above the state average experienced a slight dip in performance this quarter.



Goal:

⇨ 85% of those with case-based reviews show acceptable child status.

Of youth receiving care coordination and services through CAMHD, 84% were found to be doing well in measures of child well-being as measured through Internal Reviews. Child status was a concern for several youth reviewed in the Maui and Windward service areas.



Families will be engaged as partners in the planning process

Goal:

⇨ 85% of families surveyed report satisfaction with CAMHD services.

CAMHD has historically conducted an annual consumer survey in the spring of each year. Health Services Advisory Group, under contract with the Med-QUEST Division, now conducts a satisfaction survey for the QUEST-enrolled CAMHD population, and CAMHD will conduct the same survey with the remainder of the registered population. The survey results are not yet available.

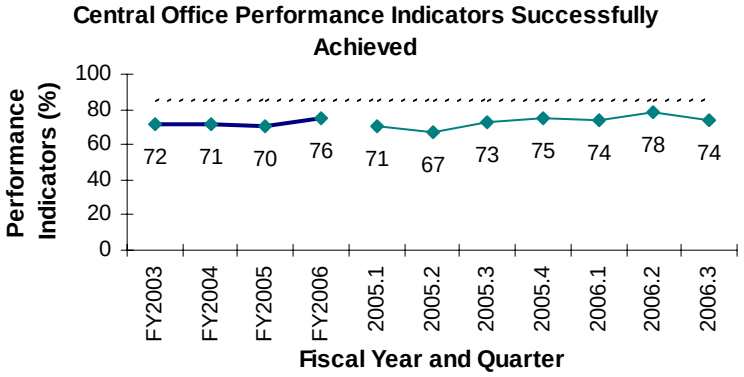
The comprehensive report of the previous year's results can be found on the CAMHD website at http://www.hawaii.gov/health/mental-health/camhd/library/pdf/rpteval/cs/cs005.pdf.

There will be state-level quality performance that ensures effective infrastructure to support the system

Goal:

⇨ 85% of CAMHD Central Office performance measures will be met.

CAMHD's Central Administrative Offices utilize performance measures for each section for accountability and planning. Central Office measures are approved and tracked by the CAMHD Expanded Executive Management Team (EEMT). There are a total of 36 measures currently tracked by EEMT. Of the 31 measures available in this quarter, 23 or 74% of measures were successfully met, which falls short of meeting the performance goal for this quality indicator and shows a slight decrease over last quarter's performance. In the quarter, the measures that fell below their goals continued to revolve around timeliness and issues related to the impact of staff vacancies.

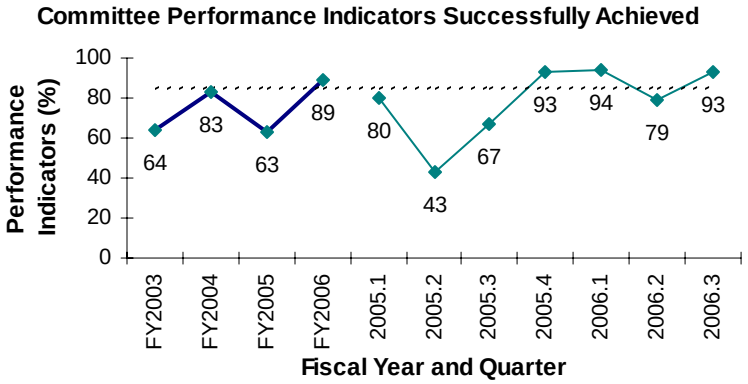


Improvements for Central Office performance measures are managed by respective sections of CAMHD. When solutions require a broader organizational intervention, these are discussed on the regular Expanded Executive Management Team level, and are tracked for implementation.

Goal:

⇨ 85% of CAMHD State Committees performance measures will be met.

The CAMHD Performance Improvement Steering Committee (PISC) reviews data for its core committees, which include Grievance Appeals, Compliance, Credentialing, Evidence Based Services, Information System Design, Policy & Procedure, Safety & Risk Management, Training, and Utilization Management.



A total of 20 measures are tracked and reported on in the monthly meeting. Similar to Central Office measures, results for each indicator are discussed in PISC meetings in order to identify improvement strategies that are implemented by respective CAMHD section managers.

In the quarter, of the 15 measures with available data, 93% were successfully achieved through the work of the CAMHD Committees. This is an increase over last quarter's performance of 79% of measures met. The only committee measure not meeting the benchmark involved the number of events reported per 1,000 registered youth. Each committee not meeting their benchmark is required to present improvement strategies to PISC.

Summary

The majority performance goals were met or exceeded in the third quarter of fiscal year 2006 (January 2006-March 2006), a substantial increase over last quarter's overall performance.

For a point of reference, the asterisked measures are those that had historically been linked to Federal Court benchmarks under the Felix Consent Decree. Of these "Sustainability" measures, indicators met the performance goal in the reporting quarter except for the following measures:

- Filled Care Coordinator Positions, which was 3% below targeted performance, but an increase of 4% from last quarter's performance.
- Filled Central Administration Positions, which was slightly below (1%) the targeted performance goal and corresponds with last quarter's performance.
- Complexes Maintaining Acceptable Scoring on Internal Reviews, which was 6% below targeted performance. Two complexes, Hana and Kailua, did not meet the goal.

The following were measures that met or exceeded goals:

- Care Coordinator caseloads within the range of 1:15-20 youth
- Maintaining services and infrastructure within the quarterly budget allocation
- Contracted providers paid within 30 days
- Timely access to the service array:
  - Youth receiving services within 30 days of request*
  - Youth receiving the specific services identified on their plan*
- Timely and effective response to stakeholder concerns:
  - Youth with no documented complaint received*
  - Provider agencies with no documented complaint received
  - Provider agencies with no documented complaint about CAMHD performance*
- CAMHD-enrolled youth receiving treatment within the State of Hawaii*
- CAMHD-enrolled youth receiving treatment while living in their home
- Coordinated Service Plan timeliness*
- Coordinated Service Plan quality*
- Performance Indicators met by the Central Family Guidance Center
- Performance Indicators met by the Windward Family Guidance Center
- Performance Indicators met by the Leeward Family Guidance Center
- Performance Indicators met by the Honolulu Family Guidance Center
- Performance Indicators met by the Hawaii Family Guidance Center
- Performance Indicators met by the Kauai Family Guidance Center
- Monitoring of provider agencies
- Quality service provision by provider agencies
- Improvements in child status as demonstrated by CAFAS or ASEBA*
- Child Status as measured by Internal Review Results
- State Committee performance indicators

The following measures were below targeted performance with observed decreases, and will require implementation of improvement strategies developed by the appropriate monitoring bodies.

- Filled Care Coordinator positions*
- Filled Central Administration positions*
- Performance Indicators met by the Maui Family Guidance Center
- Performance Indicators met by the Family Court Liaison Branch
- Complexes maintaining acceptable scoring on Internal Reviews as two complexes scored below 85%.
- Central Office performance indicators

The following measure was not completed this quarter due to regular annual scheduling:

- Overall satisfaction with CAMHD services

Of the 29 performance measures completed during this quarter, 23 or 79% of performance indicators met or exceeded goals. Nine measures that did not met their performance goals last quarter met goals in the current quarter. A little less than a quarter of the measures experienced performance declines. Of the original "Sustainability" measures, three (Filled Care Coordinator positions, Filled Central Administration positions, and Complexes Maintaining Acceptable Scoring on Internal Reviews) did not meet the performance goal, which corresponds with the previous quarter. Challenges to filling positions remain and are actively being address through the reorganization and civil service replacement initiatives. Vacancies in the MIS, Administrative Offices, Clinical Services, and Performance Management sections continue to challenge ongoing operations. Additionally, performance areas of concern in the Family Guidance Centers continue to be impacted by vacancies and the time it takes to fill positions.